NEW HAMPSHIRE BUYER'S GUIDE TO MEDICARE SUPPLEMENT INSURANCE

Prepared by
The New Hampshire
Insurance Department

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Premium rates are based on information available to the department at the time of publication and may not be representative of premiums being charged by the company today.

HICEAS

Health Insurance Counseling Education Assistance Service

- Do you have questions about your Medicare coverage?
- Would you like free and confidential assistance determining your health insurance needs?
- Are you confused or overwhelmed by all of the Medicare paperwork?
- Do you know what to do if you can't afford to pay the Medicare deductibles and co-insurance?

Since 1993, HICEAS volunteers have provided free and confidentia counseling to seniors and the disabled, answering questions about Medicare, Medicaid, Medicare supplement and long-term care insurance. At more than 25 sites throughout the state, over 200 trained and experienced HICEAS volunteers have served over 11,500 people, saving Medicare beneficiaries over $700,000.

Health Insurance Counseling
HICEAS
Education Assistance Service

Meet with a trained counselor at your nearest HICEAS site!
For *free* and *confidential* service
Call NH HELP LINE
1-800-852-3388

HICEAS is a State funded public service brought to you by the NH HELP LINE, your local Community Action Programs, and the University of New Hampshire Cooperative Extension. The project is financed under an agreement with the State of New Hampshire Division of Elderly and Adult Services of the Department of Health and Human Services with funds provided by the US Department of Health and Human Services Health Care Financing Administration. 4

Medicare Supplement Insurance

What Is Medicare Supplement Insurance?

Chances are, if you picked up this guide, you are somewhat familiar with Medicare, a federally funded health insurance program for those aged 65 and older, and for the disabled. Although Medicare may pay a large part of your health care expenses, it does not pay for all of them. **Some services and medical supplies are not fully covered!** You must also pay certain amounts called "copayments" and "deductibles." Please contact your local Social Security office for a free copy of the Medicare handbook and an explanation of what it covers.

Private insurers offer Medicare supplement policies under 10 different standard plans, which fill some gaps not covered by Medicare. These are the **only** plans that may be sold as Medicare supplement insurance policies in New Hampshire. Insurers may offer "group" and/or "individual" policies. Group insurance covers a number of people or groups under one policy, usually through employers or associations. Individual insurance covers one person. Both types of policies are sold by agents and through the mail. Coverage and prices vary widely among policies.

Federal and state governments do not sponsor Medicare supplement insurance. Do not believe agents or insurance advertisements that imply otherwise.

Do I Really Need Medicare Supplement Insurance?

Not everyone needs Medicare supplement insurance. You may have other options. For example:

You may not need any insurance. Your savings may cover health care expenses that exceed what Medicare will pay.

You may qualify for full Medicaid benefits. If your income falls below a certain level, you may qualify for Medicaid, a federal and state health care program. If you fully qualify, you probably should not buy Medicare supplement insurance. However, you should enroll in the federal Medicare

program because the two programs combined will cover most of your health care costs. If you qualify for both Medicare and standard Medicaid benefits, an insurance company cannot sell you a Medicare supplement policy.

In addition to the standard Medicaid program, the state Medicaid offices offer two other programs to help certain low-income Medicare beneficiaries meet health care costs.

You may qualify for the Qualified **Medicare Beneficiary** (QMB) program. Individuals with income at or below the national poverty level may qualify for the QMB program. This program pays Medicare's premiums, deductibles and coinsurance amounts for certain elderly and disabled persons who qualify for Medicare Part A, whose annual income falls below the national poverty level and whose savings and other resources are very limited. If you qualify for this program, insurers may not sell you a Medicare supplement policy unless it includes coverage for prescription drugs, such as plans H, I or J.

Or, you may quality for the **Specified Low-Income Medicare Beneficiary (SLMB) program.** The SLMB program is for persons entitled to Medicare Part A whose incomes are slightly higher than the national poverty level. If you qualify for assistance under the SLMB program, the state will pay your Medicare Part B premium. You will be responsible for Medicare's deductibles, coinsurance and other related charges.

For more information on these two programs, contact your Medicaid office, or call 1-800-Medicare (i.e. 1-800-633-4227) or 1-800-852-3345.

Your group policy may provide adequate coverage. If you are covered by a group insurance policy before you retire, you may be able to continue that policy after retirement. Continuation of existing coverage can mean you will not have to wait before "pre-existing" medical conditions are covered. Group policies are sometimes less expensive than individual policies, and may offer benefits such as prescription drugs and routine dental care. However, employer group insurance is not necessarily Medicare supplement insurance, and does not fall under the same rules. Furthermore, group insurance may not pay your medical expenses during any period in which you were eligible for Medicare but did not sign up for it. If you can continue your employer group coverage, be sure to ask how it covers the gaps not covered by Medicare, for what length of time benefits continue, and whether your spouse will remain covered in the event of your death. If you have a spouse under 65 that was covered under an earlier policy, make sure you know what effect your continued coverage will have on his or her insurance protection. Your employer or group insurance representative can answer these questions.

You may obtain a Medicare supplement plan even if it duplicates your retiree health plan benefits. However, this may not serve your best interests. Medicare supplement policies must pay full benefits even if the retiree plan pays for the same service. However, if the retiree health plan contains a coordination of benefits clause, it will not pay duplicate benefits.

Basic Facts about Medicare Supplement Insurance

New Hampshire residents can buy any one of 10 standard Medicare supplement plans as their Medicare supplement insurance. Under New Hampshire law, an agent may sell only one Medicare supplement policy per insured. Any additional supplement coverage sold must include a signed statement from the individual that it will replace the existing policy. This standardization of Medicare supplement policies offers many advantages to New Hampshire consumers, including:

Simplification - Insurance companies that sell Medicare supplement policies in New Hampshire can only provide 10 standard plans for you to choose from. All companies that sell Medicare supplements in New Hampshire must offer Plan A. Remember; you can buy only one Medicare supplement policy.

Consistency -All companies must use consistent labeling of their plans. This labeling includes Plans A through J, depending upon what each company offers. The benefits for each plan are identical from company to company. For example, Plan B offered by one company has the same coverage and benefits as Plan B offered by another company. Only the companies' services and premiums may vary.

Protection Against Duplicate Coverage - Duplicate coverage is expensive and unnecessary. Therefore, companies and their agents may provide you, by law, only one policy. Agents may not sell you a Medicare supplement policy if you already have one and do not want to replace it.

Replacement of Medicare Supplement Policy -You may replace your existing Medicare supplement policy with another Medicare supplement policy through either your present company or another company. If so, any portion of a **"pre-existing"** condition provision (waiting period) that you have satisfied in your existing policy will be credited to your new policy. A pre-existing condition refers to an illness diagnosed or treated, or an illness for which an ordinary, prudent person would have sought treatment or diagnosis before a policy's issue date. Pre-existing waiting periods vary from no restriction to a maximum of six months.

Credit for Continuing Coverage - Effective July 1, 1998, Medicare supplement insurers must provide certain credit for pre-existing conditions. This means your time under previous insurance coverage can reduce (or eliminate) any waiting period for such a condition.

The credit applies to your first "guaranteed issue" policy (i.e. coverage sold without a health questionnaire or medical exam). The law requires at least six months of previous "credible" or group coverage without any gap of more than 63 days.

You may have some credible coverage, but less than the required six months. In such cases, the Medicare supplement insurer must reduce your waiting period to cover a pre-existing condition by the length of time under such coverage.

Guaranteed Renewal- All individual Medicare supplement plans sold in New Hampshire must be "Guaranteed Renewable." New Hampshire law prohibits companies from canceling these policies except for nonpayment of premium or for a "material misrepresentation" on your original application. This includes deliberately providing false information or leaving out important facts.

Most companies will reserve the right to adjust premiums because of inflation, claims experience and benefit adjustments in your policy as Medicare benefits change. For example, when the Medicare Part A deductible increases, a company usually raises its premiums to pay for the increased deductible it covers in your policy.

When a company increases its premiums, it must do so for an entire policy class. It cannot single you out and raise your premiums based on your health or the number of claims you have filed.

Open Enrollment Periods - Many companies offering Medicare supplement policies reserve the right to underwrite your application -- to ask you questions about your health and habits -- when deciding whether or not to issue you one of their policies. Although underwriting is a legal and acceptable business practice, federal law requires all companies to provide residents with an "open enrollment period" when the company must accept your application and cannot discriminate in the pricing of the policy regardless of your medical history, health status or claims experience.

Your open enrollment period for Medicare supplement insurance begins the first day of the month in which you turn 65 and are enrolled in Medicare Part B. If your birthday falls on the first day of the month, however, your Medicare Part B coverage and your Medicare supplement insurance open enrollment begins the first day of the previous month. For persons under age 65 who are on Medicare, open enrollment is the 6 months after you sign up for Medicare part B.

Persons receiving Medicare before age 65, because of a disability or end-stage renal disease, can also take advantage of open enrollment when they turn 65. If you fall into this category, you will qualify for a six-month open enrollment period for Medicare supplement insurance as outlined above.

For all others, you can determine whether you are in your open enrollment period by checking your Medicare card for your Part B coverage effective date. Add six months to that date. If the current date falls within that six-month period, you may participate in open enrollment.

During open enrollment, a company cannot refuse to issue you one of their Medicare supplement policies or discriminate in the pricing of these benefits because of health status, claims experience, receipt of health care, or medical condition. Although this provision guarantees that your policy will be issued, Medicare supplement insurance companies may impose the same waiting period for "pre-existing conditions" that they apply to policies sold outside the open enrollment period.

Regulations for Your Protection -- A number of statements must appear on any Medicare supplement application (or on a separate form) to help ensure that New Hampshire policyholders are aware of their Medicare supplement options. These statements include the following:

You do not need more than one Medicare supplement policy.

If you are 65 or older, you may qualify for benefits under Medicaid and may not require a Medicare supplement policy.

The benefits and premiums under your Medicare supplement policy will be suspended for 24 months during your entitlement to benefits under Medicaid. You must request the suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

Counseling services may be available in your community to provide advice concerning your purchase of Medicare supplement insurance.

Be sure you read and understand these statements before you sign the form.

Agents who sell Medicare supplement insurance plans must ask questions to determine if you have other Medicare supplement or health insurance policies. Your responses are important.

What about Medicaid Eligibility?

You may buy Medicare supplement insurance and later qualify for Medicaid. If so, you may suspend your Medicare supplement coverage for up to 24 months. To do so, you must make a written request to the insurance company within 90 days of qualifying for Medicaid during the suspension period, you are not charged premiums and you do not receive benefits from the Medicare supplement policy.

You may become ineligible for Medicaid within 24 months of the suspension of your Medicare supplement policy. If so, your insurer must reinstate your Medicare supplement policy. You must notify your company, however, within 90 days after becoming ineligible for Medicaid.

What about New Medicare Options?

In the national news, few days go by without mention of new health insurance options for seniors. Lawmakers added "Medicare + Choice" (i.e. Medicare Plus Choice), through the 1997 Balanced Budget Act. These changes form part of an overall plan to keep Medicare financially stable through the year 2008. Beneficiaries and other concerned persons should carefully study these options before deciding what action, if any, to take.

Seniors may choose between original Medicare and several health care alternatives. The federal Health Care Financing Administration has distributed an educational handbook called "Medicare and You." The handbook lists local health plans, requirements and costs, and provides a toll-free number (1-800-882-1228 in New Hampshire) and web site (www.medicare.gov) for more information. After studying the handbook, beneficiaries may select one of these plans, **or keep their existing Medicare arrangement by doing nothing.**

Here is an overview of the major options:

Original or traditional Medicare. You can choose any provider that accepts Medicare. However, this program on its own leaves you exposed to extra costs, such as a deductible for inpatient hospital care.

Original Medicare and a supplemental plan. You may choose one of up to ten standard supplements, as explained in this guide.

Medicare "managed care." This option features a network of Medicare-approved doctors and hospitals. These providers offer care in return for regular payments from Medicare. Managed care plans come in many different forms such as health maintenance organizations (HMOs) and provider sponsored organizations (PSOs). Some ask you to use professionals within the network. Others allow you to use outside doctors or hospitals for an extra fee.

Private "fee-for-service" plan. You choose a private insurance plan that accepts Medicare beneficiaries. The plan provides benefits in return for federal compensation. Plan administrators decide how much to pay for covered services; however, your healthcare provider may charge you a limited fee for what your plan does not pay. You will also likely owe a regular premium.

Religious fraternal benefit plan. Only members of a particular society may join one of these plans. The society must meet Medicare and federal tax standards.

Medicare medical savings account (MSA). You obtain a health insurance policy with a high yearly deductible. Medicare pays a regular premium, which it deposits into your savings account. You can build up this account to pay for extra medical costs. However, you must pay a "high deductible," which often costs several thousand dollars, for covered services. In addition, providers can charge you any amount beyond what your plan will pay. Medicare will initially offer this test program to 390,000 beneficiaries.

Some beneficiaries may like controlling costs through a high deductible, but not want to obtain an MSA. The law allows -- but does not require insurance companies to offer two new Medicare supplement plans. These "high deductible" plans F and J, like the 8 other standard plans, fill some costs not covered by Medicare.

In considering Medicare + Choice, seniors should realize that the availability of some options depends upon private business and marketing decisions. It may take several years, if ever, for each option to become widely available.

Medicare Select Policies

Medicare Select offers the same basic coverage as the 10 standard plans available through traditional Medicare supplement insurance. However, companies may require consumers who obtain Medicare
Select policies to use a specific network of health care providers and/or facilities. Except for an emergency case, it depends upon the company policy whether your coverage will apply to care from a physician outside the network. Insurance companies usually charge lower premiums for Medicare Select policies than for traditional Medicare supplement policies.

When a Medicare Select policyholder receives covered services from a network provider, Medicare will pay its share of the approved charges. The Medicare Select plan will cover the rest up to the limits of the policy. In general, Medicare Select polices will deny payment or pay less than the full benefit if you go outside the network for non-emergency services. Medicare, however, will still pay its share of approved charges in such situations.

If You Have a Policy Other Than One of the Standard Plans

Medicare supplement policies sold in New Hampshire on or after Jan. 1, 1992 must be one of 10 standard plans. However, policies issued with an effective date prior to 1992 are still valid.

If you have a policy issued before 1992, you may replace it with one of the 10 standard plans. However, if you switch to one of the standard plans, you will not be allowed to go back to your old policy.

You do not need to replace your existing policy with one of the 10 standard plans. Many policies with an effective date prior to 1992 include coverage and benefits not found in any of the 10 standard plans. Also, their premiums may cost less than a comparable new policy. Before you make any changes, compare all benefits and rates between your existing policy and any new policy. To insure continuous coverage, do not cancel your existing policy until you receive confirmation that your new policy has taken effect.

Effects of Other Coverage on Your Medicare Supplement Policy

In addition to your Medicare supplement policy, you may be considering or have already purchased other health coverage such as a major medical plan, indemnity plan, or a limited benefit plan such as a cancer-expense plan.

Although a New Hampshire citizen may own any of these plans, this may create a duplication of coverage when combined with Medicare **and** a Medicare supplement policy. This **means you may pay twice for the same coverage!** Federal law now requires that a statement appear on the policy that discloses this information. Policyholders who obtain Medicare supplement insurance usually do not need other coverage.

DO YOU NEED PART B?

You may not need to buy Medicare Part B if you work and otherwise qualify for Medicare, as long as you maintain coverage under your employer's group health insurance.

Before you obtain Part B, you should review what your group plan covers and how it coordinates with what Medicare pays. You will pay a monthly premium once you enroll. Most enrollees have this premium deducted from their monthly Social Security check.

Except for the time you are covered by your employer's group plan, **your Part B premiums increase 10 percent for each year you delay enrollment past the year of your 65th birthday.**

If this situation applies to you, contact your local Social Security office before your 65th birthday.

Comparison Shopping for Medicare Supplement Insurance

Each of the 10 standard Medicare supplement plans offers a different combination of benefits. Be sure you understand plan differences.

All companies selling Medicare supplement insurance in New Hampshire must provide Plan A. In addition, they may provide any of the remaining nine standard plans, but do not necessarily have to do so. Discuss the combination of benefits for each plan with your agent.

All companies must use consistent labeling of their plans. This labeling includes Plans A through J, depending upon what each company offers. The benefits for each plan are identical from company to company. For example, Plan B offered by one company has the same coverage and benefits as Plan B offered by another company. Only the companies' services and premiums may vary.

10 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS

CORE BENEFITS	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Pl
Part A Hospital (Days 61-90)	X	X	X	X	X	X	X	
Lifetime Reserve (Days 91-150)	X	X	X	X	X	X	X	
365 Life Hospital Days – 100%	X	X	X	X	X	X	X	
Parts A & B Blood	X	X	X	X	X	X	X	
Part B Co-insurance – 20%	X	X	X	X	X	X	X	

ADDITIONAL BENEFITS	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Pl
Skilled Nursing Facility Co-insurance (Days 21-100)			X	X	X	X	X	
Part A Deductible		X	X	X	X	X	X	
Part B Deductible			X			X		
Part B Excess Charges						100%	80%	
Foreign Travel								

Emergency			X	X	X	X	X	
At Home Recovery				X			X	
Prescription Drugs								
Preventive Medical Care					X			

*** $1,250 Annual Maximum**
**** $3,000 Annual Maximum**

Please review the inserts in the back of the booklet for information about what Medicare pays and what the different Medicare supplement plans cover. Also, included is a list of companies offering Medicare supplement coverage and their rates.

Other Insurance for Seniors

Long-Term Care Insurance

Long-term care encompasses a wide range of medical, personal and social services. A person may need this care if they suffer from prolonged illnesses, disabilities, or as the result of cognitive impairment.

Private insurance companies offer individual or group long-term care insurance policies that provide benefits for a range of services not covered by your regular health insurance, or by Medicare or Medicare supplement insurance. Although long-term care policies are not standard like Medicare supplement, resulting in a wide variety of policy designs.

Home Health Care Policy

This type of policy covers services prescribed by a physician and from a Medicare-certified or a state-licensed home health care service. The care must help with activities of daily living or the supervision or protection of a patient with cognitive impairment (such as Alzheimer's disease or senility). Some policies that offer nursing home coverage automatically offer home health care as well. Some companies offer home health care as an option or rider to a long-term care policy. A few companies offer policies that cover only home health care.

Nursing Home Care Policy

This limited-benefit insurance policy offers an alternative for some people and covers either one level or several levels of care. The inability to perform

one or more of the activities of daily living or cognitive impairment activates the benefit trigger or this care.

As a person begins to plan for their long-term care needs they will hear references to various types of nursing care, including **skilled, intermediate and custodial.**

Skilled care generally involves medical conditions that require care by trained medical personnel, such as registered nurses or professional therapists. A physician orders this care, available 24 hours a day. It also involves a treatment plan.

People may need skilled care for a short time after an acute illness or injury, such as a stroke or hip fracture. However, some may require it for longer periods. A patient may obtain such care in a skilled nursing facility, nursing home or in a person's home with help from visiting nurses or therapists. Medicare and Medicaid each have separate definitions of skilled care, which may differ from this definition.

Intermediate care refers to treatment needed daily but not necessarily for the entire 24-hour day. A physician orders this care and registered nurses provide supervision. It involves less specialization than skilled care but often requires more personal care.

Custodial care involves helping a person perform the activities of daily living, such as help with bathing, eating, dressing, toiletlng, and transferring (i.e. moving into or out of a bed, chair or wheelchair). It involves less intensive or complicated service than skilled or intermediate care, and can take place in many settings, including nursing homes, adult day care centers, or at home. Sometimes custodial care is called personal care.

Life Insurance

A few companies offering life insurance policies also may offer long-term care coverage as a payout option. Under this arrangement, a certain percentage of your life insurance benefits helps to pay for long-term

Your Rights and Responsibilities

When you buy insurance, you have certain rights and responsibilities.

Your Rights:

You have the right to receive an outline written in easy-to-understand language. The outline explains your policy's benefits, exclusions and limitations.

You have the right to receive copies of all forms and applications signed by you or the agent.

You have the right to receive your policy within 30 days. If you do not, contact the company and request a written explanation. If you have not received an explanation within 60 days, contact the Insurance Consumer Helpline toll-free at 1-800-852-3416. Follow the same schedule if you return a policy and do not receive a refund.

You have the right to have 30 days to review a policy. This is called a "free-look period." If you decide you do not want to keep the policy, return it to the company by certified or registered mail with the return receipt requested. You must do this within 30 days of receiving the policy to be eligible for a full refund.

You have the right to have your policy renewed unless you do not pay your premiums or deliberately give misleading information on your application. Your rate may change but only if the company changes everyone else's premium in your policy class. You cannot be singled out and have your premium increased because of your health or the number of claims you have filed. A company cannot cancel your policy because of your age or any medical condition that occurs after you obtain your policy. Your policy will state the conditions under which the company may raise your premiums.

You have the right to appeal any claim denied as not medically necessary to a licensed physician designated by your insurer.

You have the right to receive a free copy of the federally approved buyer's guide, titled "Guide to Health Insurance for People with Medicare," from the agent who sells the policy. This guide explains the Medicare program, Medicare supplement insurance, HMOs and other health insurance options for Medicare beneficiaries.

You have the right to have your claims paid promptly. If you use a participating Medicare physician or provider, he or she must file your Medicare and Medicare supplement claims for you. If you use a non-participating Medicare physician or provider, he or she must file your Medicare claim, but is not obligated to file your Medicare supplement claim. The physician or provider cannot charge you for filing claims.

You have the right to obtain a prompt refund of unearned premiums if you or your company cancels your policy.

You have the right to have pre-existing conditions excluded for no more than six months after your policy goes into effect. A pre-existing condition is an illness known about, diagnosed or treated before you buy a policy. Report all illnesses when applying for insurance. If your company learns of an unreported pre-existing condition, it may either refuse to pay claims or cancel your policy.

Your Responsibilities:

You are responsible for reading and understanding your insurance policy.

You are responsible for reading and understanding any "explanation of benefits" forms sent by your insurance company. Such a form will usually state: "This is not a bill." However, you should still closely study it to find out whether you actually received the services described. You should contact your company for help if you do not understand the form or have trouble reading or speaking English. If your company does not send out such forms, call to ask why; after all, careful scrutiny of these forms can help you and the insurer detect and fight fraud.

You are responsible for reporting suspected fraud to the Department of Insurance. For example, you may examine your health insurance records to find out that your insurance company was billed for services never rendered. If you suspect such a crime has occurred, call the department of insurance at 1-800-852-3416.

You are responsible for making sure your application is correct. This includes information on preexisting conditions. If you make a fraudulent mis-statement, the company may cancel your policy or refuse to pay a claim.

You are responsible for knowing what your policy covers and excludes.

You are responsible for maintaining continuous coverage. Do not cancel your old policy before the company has accepted your application and your new policy is in force.

You are responsible for paying your premiums, even while involved in a dispute with your company.

You are responsible for paying the deductibles outlined in your policy.

You are responsible for verifying licenses of an insurance agent and company by calling the Insurance Consumer Helpline toll-free at 1-800-852-3416. **A business card is not a license!**

How to Select an Insurance Agent

Most agents are reputable professionals who have been trained in their area of expertise. Insurance agents must take classes and pass certain tests to become licensed. Some agents choose to take further courses to obtain additional professional designations. These designations include:

LUTCF ..... Life Underwriting Training Council Fellow
CFP ..... Certified Financial Planner
CEBS ..... Certified Employee Benefits Specialist
CIC ..... Certified Insurance Counselor
CLU ..... Chartered Life Underwriter
CPCU ..... Chartered Property and Casualty Underwriter
RHU ..... Registered Health Underwriter
ChFC……. Certified Financial Consultant

When selecting an agent, choose one who is licensed to sell insurance in the state of New Hampshire. Also, choose one with whom you feel comfortable and who will answer your questions. To verify whether an agent is licensed, call the insurance department toll-free at 1-800-852-3416.

How to Select an Insurance Company

When selecting an insurance company, it is wise to check on a company's rating. Several publications, available in your local library, rate insurance companies. These publications include: A. M. Best, Standard and Poor's

Corp. (S&P), Weiss Research and Moody's Investors Service. Companies are rated on a number of elements, such as financial data (including assets and liabilities), management operations and the company's history. You may also wish to review a company's stock analysis reports.

Consumer Tips

Shop carefully before you buy. Compare benefits, services and costs.

Take your time. Professional agents do not pressure their customers. If you are unsure about a policy, ask your agent to explain it to you again in the presence of a friend or relative whose judgment you respect.

Mail-order policies may lack service. Companies that sell mail-order policies may not have local agents or toll-free numbers, thus making it difficult to get answers to your questions. If a policy is sold through the mail, a toll-free number should be available.

Read your policy and be sure you understand what **it covers and excludes.** Know how your policy coordinates with other coverage you have.

Make sure all information on your application form is correct. An incorrect form may cause your insurance company to cancel your policy or leave you with unpaid claims. Do not be misled by agents who tell you your health history does not matter. Describe your health status accurately. It is best to fill out this information yourself. If the agent fills it out, do not sign it until you have made sure all the information is correct.

Do not pay cash. Pay by check, money order or bank draft made payable to the company, not the agent. Do not give your agent a blank check or access to your account. If you have an automatic teller machine (ATM) card, do not give out your access number.

If you do not receive your policy in 45 to 60 days, contact the company or agent. If you have no success in receiving your policy, or suspect fraud, contact the Insurance Consumer Helpline toll-free at 1-800-852-3416.

Get help. If you have questions or cannot resolve a problem with your insurance company or agent, contact the Insurance Consumer Helpline toll-free at 1-800-852-3416.

Insurance Fraud Costs Us All!

Insurance fraud can increase premium; in fact, it can inflate your premiums by as much as 30 percent, according to the National Insurance Crime Bureau. This includes the money you pay for life, auto, health, homeowners' and other types of insurance.

You can protect your personal and family pocketbook by learning about the many different types of fraud schemes and scams.

Some common examples include:

Fictional visit - A home health care provider bills the Medicare program for unnecessary, unauthorized or fictional visits to a patient.

Receipt of kickbacks -A nursing home receives illegal kickbacks from a mental health hospital for new patient referrals.

Agent stacking - An insurance agent commits "stacking" by selling a senior unnecessary health insurance which duplicates Medicare supplement coverage.

Unauthorized referral - A laboratory bills Medicare for a patient's tests using information stolen from a referring physician. In actuality, the physician has never seen the patient.

Deceptive billing -A senior sells insurance information to a health care provider who bills Medicare for services never rendered. In some cases, such providers bill for as many as 800 phony services for one senior in a three-month period.

There are many other types of insurance fraud: if you suspect such a crime has occurred, call the New Hampshire Insurance Department toll-free at 1-800-852-3416.

**Source.' The Coalition Against Insurance Fraud.*

Glossary

The following definitions will help you make a more informed decision when buying Medicare supplement insurance.

Activities of Daily Living (ADLs)
Normal everyday tasks such as bathing, eating, dressing, toiletlng and transferring from one place to another (for example, moving from a chair to a bed).

Actual Charge

The amount a health care provider bills a patient for a particular medical service or procedure. It often differs from the Medicare-allowable charge.

Allowable Charge
The maximum fee Medicare uses in reimbursing a provider for a given service. Allowable charges are sometimes called "reasonable charges."

Assignment
A method by which your doctor or medical supplier receives the medical insurance payment directly from Medicare. Under assignment, you can save time and money because your doctor or medical supplier agrees to charge. Medicare's approved fees for covered services. Not all doctors take Medicare assignment or charge Medicare's reasonable fees. To find out if your doctor takes such assignment, call the toll-free Medicare number at 1-800-882-1228.

Benefit Maximum
The limit a policy will pay for a given benefit. A benefit maximum can be expressed either as a length of time, for example, four years, or as a dollar amount, for example, $1 million.

Chronically Ill
The inability to perform, without substantial assistance from another person, at least two activities of daily living (i.e. normal daily tasks such as eating, bathing, dressing, etc.) for a period of at least 90 days due to severe cognitive impairment.

Cognitive Impairment
A deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Coinsurance
A percentage or dollar amount of an expense or service covered by insurance that you are required to pay.

Coordination of Benefits
A method of integrating payments by more than one insurance policy so that benefits from all sources do not exceed 100 percent of the bills.

Deductible
The amount you must pay for medical expenses before your insurance will pay. This fixed amount must be paid by you or your Medicare supplement policy. For example, with Medicare you must pay a $812 deductible for each hospital stay unless your supplemental policy pays this cost.

Duplication of Coverage
When an agent sells you more insurance than you need. It is also called "overselling" or "stacking."

Exclusion
Any condition or expense for which the policy will not pay. For example, long-term care policies will not pay for treatment that should be paid for by the government (except Medicaid).

Free-Look Period
A period of time after receiving a policy that you have to decide whether or not to buy it. The law allows you 30 days to make your decision. If you have paid a premium during that 30 days, and decide not to keep the policy, you may receive a full refund. Be sure to return the policy to the company by certified mail within 30 days to guarantee your refund.

Group Insurance
Insurance that covers a number of people or groups under one policy. Most health insurance available from employers is group insurance. Group insurance usually costs less than individual insurance.

Guaranteed Renewable Policy A policy in which the insurance company agrees to insure a policyholder for life. Premiums may change, however, if changed for all people within the same class of risks in the state. The company may cancel a guaranteed renewable policy for two reasons: the policyholder or a secondary addressee, if chosen, failed to pay premiums within 30 days of receiving a notice of possible lapse in coverage; or the policyholder deliberately misrepresented or left out key information on the application. All Medicare supplement policies sold in New Hampshire are "guaranteed renewable."

Home Health Care
Intermediate or custodial care received at home from a nurse, therapist or home health aide under a doctor's supervision.

Individual Insurance
Insurance that covers one person under one policy.

Lapse
Voluntary termination of a policy by the policyholder.

Levels of Nursing Care
Various degrees of nursing care. The three levels often referred to in Medicare, Medicare supplement, and insurance policies include the following:

Skilled Nursing Care - Daily (around-the-clock) nursing and rehabilitative care performed by or under the supervision of a registered nurse or a doctor.

Intermediate Care - Less than 24-hour daily nursing and rehabilitative care performed by or under the supervision of skilled medical personnel. A registered nurse or a doctor must supervise care.

Custodial Care - Care not requiring a nurse that is provided in a nursing home or private home. This includes help with activities such as bathing, dressing, eating or taking medicine. A doctor must recommend care. A Medicare supplement policy provides limited nursing home care. It supplements Medicare payments for skilled nursing, but not intermediate or custodial care.

Lifetime Reserve Days
Sixty extra days of Medicare Part A coverage, provided when a patient is confined to the hospital for more than 90 days. You do not have to use the 60 days all at once. These reserve days are not renewable; once used, they are gone.

Long-Term Care
The kind of everyday care an individual needs in the event of a chronic illness or disability. Long-term care can be provided in a nursing home, a private home or community setting.

Medicare-Eligible Charges Expenses approved by Medicare. Policies that stipulate this term will pay only for these expenses. Medicare-approved charges are often less than actual billed charges. Be sure you understand what Medicare does and does not cover.

Pre-existing Condition
A condition in which medical advice or treatment was needed, recommended by or received from a health care provider within a six-month period before the date the insured person's coverage took effect. This phrase can also refer to an illness for which an ordinary, prudent person would have sought treatment. Preexisting conditions usually are not covered until sometime after the policy has been in effect.

Premium Waiver
The suspension of premium payments after you have been receiving benefits from the policy for the period specified in the contract. Premiums will resume according to the specifics of the contract.

Rider
An attachment to an insurance policy that adds benefits to the original contract.

Secondary Addressee
A person designated by the insurance policyholder to receive any notice of possible lapse in coverage.